THE JOURNAL OF SCHOOL HEALTH

VOL. XV No. 2

FEBRUARY
1945

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639 Third St.,
Des Moines, Iowa.

PUBLISHED BY
THE AMERICAN SCHOOL HEALTH ASSOCIATION

AMERICAN SCHOOL HEALTH ASSOCIATION

Organized 1927

Devoted to the interests and advancement of those engaged in school health activities and the service rendered by them

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Published monthly, except July and August, at Buffalo, N. Y.

THE AMERICAN SCHOOL HEALTH ASSOCIATION

3335 Main St., Buffalo 14, New York

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SUBSCRIPTION RATES TO THE JOURNAL

Membership dues, $2.00, including $1.75 subscription. Subscription $1.75. Single copies 25c

Address all communications to

THE EDITOR, The Journal of School Health
3335 Main Street, Buffalo 14, New York

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The American School Health Association

Entered as second-class matter at the Post-Office at Buffalo, N. Y. October 5, 1937

SHOULD VITAMIN D BE GIVEN ONLY TO INFANTS?

VITAMIN D has been so successful in preventing rickets during infancy that there has been little emphasis on continuing its use after the second year.

But now a careful histologic study has been made which reveals a startlingly high incidence of rickets in children 2 to 14 years old. Follis, Jackson, Eliot, and Park* report that postmortem examination of 230 children of this age group showed the total prevalence of rickets to be 46.5%.

Rachitic changes were present as late as the fourteenth year, and the incidence was higher among children dying from acute disease than in those dying of chronic disease.

The authors conclude, "We doubt if slight degrees of rickets, such as we found in many of our children, interfere with health and development, but our studies as a whole afford reason to prolong administration of vitamin D to the age limit of our study, the fourteenth year, and especially indicate the necessity to suspect and to take the necessary measures to guard against rickets in sick children."

*R. H. Follis, D. Jackson, M. M. Eliot, and E. A. Park: Prevalence of rickets in children between two and fourteen years of age, Am. J. Dis. Child. 66:1-11, July 1943.

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THE JOURNAL OF SCHOOL HEALTH

Devoted to the interests and advancement of school health service and instruction. Your participation by membership is solicited.

Vol. XV FEBRUARY, 1945 No. 2

THE CLASSROOM TEACHER RELATES THE HEALTH PROGRAM TO WAR-TIME NEEDS*

MARIE SWANSON, R.N., M.A.,
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In this discussion on "The Classroom Teacher Relates the Health Program to War-Time Needs", I will devote most of the time to how "the classroom teacher relates" rather than to the other phases of the topic, "health program" and "war time needs". In order to do this, I am going to assume your familiarity with four papers given at the meeting of the American Public Health Association here last October. I believe this assumption is safeguarded by the fact that the papers were so recently published (in the July 14th and 21st issues of Public Health Reports of the United States Public Health Service.) I refer to the series on "Planning for Health Education in the War and Post-War Periods" given by Dr. E. R. Coffey in relation to the National Program;[1] by Dr. J. C. Knox on the State Program;[2] by Dr. H. B. Robbins on the local program[3] and by Dr. John W. Studebaker on the school program[4].

I would like to begin with several of the principles which each of them considered important such as, (1) the necessity for applying the democratic process in the conduct of the health program; (2) the value of arranging the program whether on the National, State or local levels of administration so that it will actually get into the lives of the individuals of the communities, (3) the emphasis on decentralization—that is the National agency assigning its worker to a State instead of trying to work on a National level; the State Agency assigning a worker to the local agency; the local agency sending the worker out into a small community group. As Dr. Knox said, "The pipe line of health education must necessarily reach all the people."

I am sure all agree that if the health program is to function in the lives of the pupil and his parents, in his school living and in the rest of his daily living, it must be the classroom teacher who does

* Presented before the American School Health Association, New York, October 2, 1944.

most of the "relating", that is, the application of the planned program to the actual living of the pupil and his family. We admit she can't do it alone any more than others can do it without her. She must be assisted by the pupil and his parents, by the school physician and dentist, not as they sit in their offices and make plans or outline programs, but as they have actual contact with the individual children. She must be assisted by the nurse and dental hygienist, by the cafeteria director and audiometer technician, by everyone else in the school who handles the pupils directly.

Administrators, medical directors, health education supervisors, may propose and publish the most beautiful of programs, but the program's relation to the pupil, its effectiveness in his life is established, or **not** established by those people who have a personal contact with the individual child and his parents. Of all of these the teacher leads the rest by a wide wide margin; the others have but a small fraction of her opportunity. In war time or peace time this is true.

Probably the chief differences in the war time and peace time needs that the classroom teacher must meet, are, as Dr. Robbins pointed out, that the war has reshuffled the relative importance of the problems; almost without exception, old problems have increased; new ones have been created; and, greatest difficulty of all, resources to help the teacher meet problems have been drastically cut. In the school there are fewer physicians, dentists, nurses and technicians; in the community, medical nursing and dental care have been reduced; the school buildings have become less sanitary; sanitary supplies have been curtailed, and even the reduction in travel facilities complicates many health problems.

War time needs have had but one beneficient feature that I have been able to find, that is, that they have been so extreme, at times so terrific, that they have demanded and received an attention they could not obtain in peace time.

When we expect the teacher to do a good job of relating the health program to the needs of her pupils, we are presupposing the existence of a good program, well organized and coordinated; the planned program I referred to earlier, with clearly defined objectives, with carefully specified and definitely allocated responsibilities. It is not enough to notify the teacher for what she is responsible; she is entitled to a full understanding of what responsibilities are allocated to others and further, just which ones to which people. If she is to do a superior job of "relating" the health program to the pupils' needs she should have had a part in the setting up of that program, in each step of its development, in the enumeration and

analysis of the health problems upon which the program is based, in the survey of local resources that may be used in meeting them, in developing the plan to use the resources to solve the problems and, finally, in allocating the responsibilities.

This participation in planning will help her to an extent and in a manner which nothing else can. It will protect her against a feeling teachers may get, sometimes justly, other times unjustly — that because they are nearest in the school system, geographically, to that ultimate consumer, the pupil, therefore, "everything is shoved off on us."

But there is other assistance though less important that the teacher can be given in discharging this obligation. For instance if school physicians and nurses are obliged to decrease the actual service they can give in the school's health supervision of the pupil they should require themselves to assist the teacher in improving her ability to carry her added load, to furnish her with a continuous flow of information regarding the new situation she may encounter, the new circumstances which develop.

Among the war time needs which the teacher finds most pressing are:

1. To give the pupil emotional security.
2. To give a more highly sensitized health supervision to him during his school hours.
3. To help his parents plan to give (or in some way to compensate for the lack of giving) health supervision of his out-of-school hours.
4. To help his parents plan to get medical and dental care for him in the fact of the increased difficulties encountered in doing so.
5. To help his parents see that proper food is available to him, and (this is crucial) that he develops an interest in the selection and eating of food that best meets his needs.
6. To help him learn to want adequate rest and to help him and his parents to plan it in spite of the many factors tending to interfere.
7. To help him learn to want wholesome and safe recreation, and to help him, his parents and the community plan for and provide it in spite of many negative and destructive influences.

We could continue to add to this list of war-time needs but instead we will discuss each of these briefly:

1. To give the pupil emotional security seems not only the most important but is definitely the hardest for the teacher to manage. Next to his parents, it is from the classroom teacher that the American school child of today obtains — (or does **not** obtain)

the emotional security and re-assurance which is so vital if the impacts of his war torn world are not to damage him. His predominant war-time school need is to live his daily school life in a classroom atmosphere that will make life endurable for him; that gives him an opportunity to develop a personality stable enough to withstand the strain of living in this world, which to him has developed some very unsatisfactory features.

This has become more difficult to do because children are more restless in school. They absorb the nervous tensions of their fathers and mothers. They are "harder to manage" and this wears the teacher down and her margins of self control and serenity are reduced. Her work is often harder; she may be doing teaching for which she is less well prepared; the equipment is less good, because of curtailed funds or unavailability of material. There is pressure on her to cover more subject matter in less time; actual teaching time is reduced by attention given to the many worthy projects sponsored by the school, by releases of pupils for working, by unexpected school closing because of heating or transportation difficulties.

While accustomed routine does much to give little children a sense of security, the sense of security or insecurity which they absorb from the adults around them is vital and many of them are with no other one person as much as they are with their class room teacher.

She bears not only an increased professional strain but usually has had her personal problems increased by the war. A health program which is planned to include professional guidance in the field of teacher's health, to quote the proposed Report on the Educational Qualifications of School Physicians,[5] can give her real help. "The teacher's mental as well as her physical health is of direct concern to her employer, because of its effect on the quality of her work". Another function proposed in the same report is helpful "medical advice to school authorities on mental and emotional health influences—such as length of the school day, extra curricular activities, the frequency of recess periods, the type of examinations, methods of marking and technique of handling individual children".

Not only does this moral obligation to help the teacher resolve her own personal problems and to develop a schedule of working and living that is possible to carry without too much exhaustion and irritation, belong to the school health service personnel, but it is shared by school administrators, boards of education, the general public. If they will give evidence they consider the teacher is en-

gaged in a job that is supremely vitally important, it will assist by giving her that greatest help one can have in carrying heavy psychologic and physical responsibilities, a sense of being engaged in a job than which there is none more important for one to do.

2. Our second point, to give a more highly sensitized health supervision to the pupil during his school hours includes sensitivity to a number of things. Is he properly fed? Adequately clothed, in rain, in cold, in heat? Are his small illnesses caught and attended to promptly? She keeps especially in mind those pupils who get up in the morning and come to school having had no adult supervision until they arrive there. She reacts quickly to indications that a child has had little or no breakfast or that he is chronically underfed or perhaps that he lacks sleep or that he seems unhappy. The first requirement is to find out "why". Even though social workers, nurses and visiting teachers might by some odd chance abound in an unusual school, she should not call upon them until she has studied the situation carefully to determine this reason as her opportunity to learn the truth is greater than theirs because of her established intimacy with the pupil. She waits to turn the problem over to a specialized worker (or to follow it up herself) until she has classified it in her own mind, whether it is just an isolated instance, not apt to occur again, safe to ignore until it does occur again, or possibly it is a situation enough in the child's own control so she ought to be able to handle it through working on him in school. It may be and this is the case that demands immediate action, that she concludes it is serious in itself or it will be repeated if not firmly handled or the child is helpless in the circumstances and contact must be made with his guardians or with community agencies in order to protect him. In such situations she goes for help to the specialists available or she herself goes to the parents. It is easy to imagine the effort and time she may save for herself and others if she has been well instructed in the classification of such cases, if she realizes relative importance of various behavior and misbehavior manifestations. The health service staff has a responsibility for such instruction.

Likewise the better informed she is regarding the possible significance of physical signs and symptoms, the more accurately she can take a temperature, the more complete her observations, the more lucid her telephone report to the school physician or health officer, the time and effort she may save herself and the physician are obvious.

Lucky the teacher (and those with whom she works) if she has

learned to distinguish betwen a real health hazard in clothing or personal cleanliness and a mere variation between her own personal taste and that of the child and his family, who can ignore an untidy dirty bandage applied over a properly cared for wound, but become concerned over a clean piece of adhesive neatly placed over an open wound, who is immune to the dirt on saddle shoes, but who sees to it that even the "junior highs" wash their hands before lunch; who has no emotional reaction to the homliest of unstockinged adolescent female legs but reacts immediately to a damp shivering child.

Because of lessened medical and nursing service, the teacher's recording of health behavior and her history of accidents, illnesses and treatments becomes increasingly important. An accurate complete history magnifies the value of the limited professional time that may be given to the child.

The third point, to help his parents plan to give (or in some way to compensate for the lack of giving) health supervision to him in his out-of-school hours, may mean teacher-parent conferences at school or in the home or it may mean the teacher's participation in community planning to provide for such health supervision when parents cannot. Her part may be restricted to agitating the problem sufficiently to school and community leaders so they will take action, and she will not have to. From the pupil's mother the teacher must adjust herself to expect to receive less help in solving his school health problems and to expect to give his mother more help in dealing with his out-of-school problems, as the mother's situation in looking after a family of children has become more formidable, even in those instances where war-time demands have not taken her (actually) from the home.

4. To help the pupil and his parents plan to obtain the medical and dental care he needs in face of the increased difficulties arising in doing so, presents another instance where the school health service is charged with supplying definite help to the teacher if she is to function successfully. Making school policies relative to excusing pupils for certain times of day when medical or dental time is most available; assisting parents in scheduling appointments; arranging (though not necessarily supplying) transportation; stimulating creation of some special facilities for care of groups of children that will conserve professional time in rendering the service; each of these has been done in some schools.

The individual teacher can do little such planning alone, but she can participate in it effectively. Under proper advice, she can do more than anyone else to put such plans into action.

5. To help his parents see that proper food is available to him

and that he develops an interest in the selection and eating of the food that best meets his needs. His parents may purchase and prepare the best of foods; the Federal Government may spend its millions for adequate school lunches, the State may supervise the construction and management of an ideal cafeteria system in his school, an attractive menu of tasty food may be served to the pupil, and if he doesn't want to eat it he will not. Teachers, especially in the lower grades, are notorious (to some parents) for their success in influencing the likes and dislikes of their pupils. When you add to this the pressure exerted on the individual child by the actions and attitudes of his group, it is obvious how much a school may do which an individual parent might be helpless to accomplish in the way of changing poor attitudes toward eating and food to desirable ones. Here again though the classroom teacher is the one most effective person to work on this problem, it is unfair to just hand it to her. Once more she should participate in the planning, know the part for which she is answerable, and have a feeling of working with the entire group on a mutual problem.

6. To help him learn to want adequate rest and to help him and his parents plan for it in spite of the many factors tending to interfere. The pupil's rest at home is of greater importance but if rest is indicated during the school day for a group or individuals, while the teacher is the one who can see that they get it, such activity on her part again must be preceded by planning in which the health service participates with her.

7. To help him learn to want wholesome and safe recreation and to help him, his parents and the community plan for and provide it in spite of many negative and destructive influences. The classroom teacher's most valuable contribution may be in arousing consciousness of the problem, which she, more than most others, is in a position to observe first hand.

If the classroom teacher is to be effective in relating the health program in these seven and other areas of war-time needs, we other workers must make her feel that she is not left alone with an appalling responsibility.

Her burden is made more bearable if the school health specialists and, with them, the general public frankly admit to her that a pupil's attainment of optimum health does not rest entirely on her shoulders; that it is related to numerous influences many of which as Dr. Studebaker pointed out, are outside the school, such as the income of the parents, home dietary standards, community sanitation, parental and community provision of medical care and recreation.

She may concern herself very importantly in getting community agencies organized to work on home dietary standards, sanitation, medical care and recreation. However, we cannot consider her, and she herself need not feel responsible in those areas, as she is expected to feel herself personally responsible in relation to a dirty or a sick or an unhappy child in her classroom. Effective action in such circumstances is her unique contribution in relating the health program to war time needs.

1. Coffey, E. R.—Planning for Health Education in the War and Post-War Periods—the National Program. Public Health Reports. 59, 28: 897—July 14, 1944.
2. Knox, J. C.—Planning for Health Education in the War and Post-War Period—the State Program. Public Health Reports. 59, 29: 933—July 21, 1944.
3. Robbins, H. B.—Planning for Health Education in the War and Post-War Periods—the Local Program. Public Health Reports. 59, 29: 938—July 21, 1944.
4. Studebaker, J. W.—Planning for Health Education in the War and Post-War Periods—the School Program. Public Health Reports. 59, 28: 904—July 14, 1944.
5. Shepard, W. P.—Report of Committee on Professional Education (Proposed Report on the Educational Qualifications of School Physicians.) A. J. P. H. 34, 9: 977—September 1944.

Biology In High Schools,—The committee's report* was based on information secured from 3,200 teachers of one or another biologic subject (biology, zoology, botany, physiology, general science) in 3,000 high schools located in all parts of the United States. In general, these schools were better than the average high school and had a larger than average enrollment. Nevertheless, only 53 per cent of these teachers said they had trained especially to teach biology; 14 per cent reported that in the curriculum of their school a unit of biologic study had been replaced by a social study within the past five or ten years; 39 per cent stated that extracurricular school activities interfered much or seriously with their teaching; only 70 per cent were teaching in rooms specially equipped for their subject; many teachers—apparently baffled by the limitations of time and facilities for teaching a science—largely abandoned effort to do so and focused instead on technologic items such as conservation, sanitation, forestry, health, nutrition and economic biology.

The facts that all future citizens should know of plant science, animal biology and human physiology and hygiene, together with the many personally significant applications of these sciences, cannot be learned in two years. Study of these life sciences for two years would account for only one-tenth of the total effect of the high school pupil. Yet this field of study included what is known of our physical selves, of our relation to the living environment of plants and animals, and of the sources of our food, clothing and shelter. This is the subject of which Charles W. Eliot, chemist and former President of Harvard, said, "The human race has more and greater benefits to expect from the successful cultivation of the sciences which deal with living things than from all the other sciences put together."

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* Riddle, Oscar, editor, and others: The Teaching of Biology in Secondary Schools of the United States: A Report of Results from a Questionnaire, Lancaster, Pa., Science Press, 1942, pp. 1-76. Editorial, Journal A.M.A., June 3, 1944, abstracted by C. H. Keene.

THE SCHOOL HEALTH EXAMINATION AND SOME FOLLOW-UP SERVICES

By CHARLES B. LEWIS, M.D.

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The prime purpose of the health examination and follow-up services is to discover, if possible, defects which might interfere with the child's mental and physical progress. The health examination is not only the initial step in the education of the child but also the core of the school health program. Once discovered, remediable defects should be made the basis of appropriate corrective measures in order that instruction offered by the school may yield satisfactory returns. A sick or handicapped child cannot be educated to the extent to which he is justly entitled. It must be realized that the mind is only one part of the body and its receptive power depends largely upon the vitality of the body which feeds it energy.

The health examination is one of several methods which the school uses for studying the pupils in its charge in order that it may better fulfill the purposes of education. A good school health examination seeks to detect and prevent communicable disease and to promote optimum physical status by first determining the individual's health condition and then adjusting the school program to meet his individual needs. In addition, it detects remediable defects and encourages corrections. It seeks to educate the individual to desirable health attitudes, habits, and knowledge by developing in him an interest in his own physical status and by indicating to him through an examination by a school physician how he may attain his optimum physical health. Many schools in addition, use the health examination as a motivating activity for the teaching of hygiene and physiology.

There continues to be considerable evidence of cooperation between home and school in the presence of parents at the health examination of their children. This has advantages as follows: the physician has an opportunity to inquire into the pupil's history, habits, complaints, and home conditions. It facilitates interpretation of findings to parents by giving an opportunity for questioning and explanation. It brings together the principal, parent, physician, nurse, and teacher — all of whom are concerned vitally in the supervision of the pupil's health, growth, and development. The personal contact insures a higher percentage of corrections and creates a feeling of friendliness on the part of the parents.

The educational aims of the health examinations are as fol-

lows; to inform parents, and secure their cooperation by notification and personal conference; to secure correction of defects by individual conferences and follow-up; to inform class teachers and thus secure such desirable adjustments as favorable seating in classrooms and to secure program adjustments in relation to behavior and absence problems. In addition, the health examination has value as a basis for health instruction and for assignment for rest periods. In short, it remains the best single device with which to encourage correction of all remediable defects before the graduation of students from high school.

According to Dr. William H. Burnham, late of Clark University, considered by many the highest authority on child and school hygiene, the examination of the child at school entrance should be participated in by the teachers and parents as well as the school physician and nurse, and should include tests of physiological age, psychological age, and general health conditions as well as history of the morbidity of the individual child.

Of course, this type of examination is ideal. As such, it would constitute a most thorough review. It would take, however, considerable time and involve large expense. Yet such thoroughness would be absolutely worthwhile, says Dr. Burnham, if the child should give his first year at school to health and motor training.

Dr. Burnham gives specific reasons for such a thorough-going health examination. These are: "1. To prevent those children who are in ill health or who are not sufficiently developed physically and mentally from entering. 2. To provide the physical data necessary for the arrangement of a program that will not result in injury to health or a check to development, as often happens in the first year of school life. 3. To grade and adapt school occupation properly to individual capacity at the outset of school life. 4. To give school physicians the data for safeguarding the health of children against contagious diseases, and the like. 5. To give teachers proper knowledge of the new pupils and the right attitude toward them. 6. To permit children to begin right and to be saved from unnecessary failures and retardation or elimination in later years. 7. To educate the parents and foster a right attitude toward the schools." This again is ideal. Yet we may hope to approximate our ideals.

The standard program, however, involves a thorough pre-school examination of every child, followed by an examination once a year thereafter. Some contend the annual examination is unnecessary and advocate the following plan as making possible a more thorough examination at reasonable cost: examination of all pupils before

entrance, i.e., pre-school, in the first year of school, and in grades four, seven, and ten; also all special groups: crippled, open air, cardiacs, hard of hearing, sight conservation, speech, backward and subnormal classes, with health screenings during intermediate years and more frequently examinations only for those showing defects or chronic ailments of a more serious nature. The annual program may be preferable if it does not result in superficial diagnosis. A thorough examination — one that affords opportunity for real education at the time when it is made — is fundamental to the whole health program.

It seems doubtful whether, on an average, more than about eight or ten adequate examinations can be made in an hour by one physician, especially of children in the lower elementary grades, even when assisted by the nurse who aids in completing the non-technical phases of the examination. This number may be increased to twelve in the upper grades.

The examination should further include the eyes, ears, nose, throat, teeth, glands, skin, heart, lungs, abdomen, back, extremities, nutritional, orthopedic, and nervous conditions, mental and emotional states, and general health tone. Certain facts pertinent to the examination such as weight, height, and age, can be supplied by the nurse and teacher. The nurse might conduct some of the non-technical phases of the examination under the direction of the physician, although all features involving technical knowledge of physical conditions should be examined directly by the physician. When the service of the physician is not available, a health screening or inspection can be made by the classroom teacher or nurse to detect and select those pupils most obviously possessing health defects who should be referred to family physicians for complete examination and technical diagnosis. Individual health record cards should be kept, following each child throughout his school career.

The teacher is in the strategic position to become a most potent factor in the health interest of the child in the daily opportunity for observing the signs which give tentative evidence of existing disease or defects. The teacher is not permitted by law to conduct examinations or to diagnose, but because of her position of responsibility, it is expected that she be ever on the alert to detect what appear to be defects, abnormalities, or disease, and that she report her *suspicion* to the school physician or nurse. This report may be made the basis of an examination by the physician. The teacher should be requested to look for and report on one or more of the following items: decayed teeth, mouth-breathing, eyestrain (crusted

or red eyelids) defect of vision or hearing, malnutrition, unusual pallor and breathlessness, skin or scalp disease, general nervousness, fatigue and disinclination to play, etc.

If possible, the examination by the physician should be made with the child stripped, at least to the waist, or clothed with a slip-over. The parents, preferably the mother, should be present, especially during the examination in the early years of school life when the child is too young to profit much from instruction by the physicians or nurses and the parent must receive the instruction for the child. The presence of the parent at the examination also makes for better cooperation and the program of follow-up is usually more effective, although such a plan may not be feasible with older girls and boys in the junior and senior schools.

The nurse is primarily responsible as regards the health examination for the following: 1. Arranging with principals and teachers the schedule of examinations. 2. Overseeing the preparation of facilities and equipment for the examinations. 3. Having all records and report forms in readiness. 4. Sending announcements and invitations to parents of pupils entering school for the first time. 5. Consulting with the school physician regarding the examinations. 6. Conducting preliminary tests before the physician starts his part of the examination. The items covered by the nurse will vary, but the following are some of the tasks frequently assigned: history taking, weight and height, vision test, and hearing test. 7. Meeting pupils at time of physician's examination and helping them to open, loosen, or remove clothing. 8. Recording physician's findings on the individual health record cards together with educational implications. 9. Presenting notification of defects to parents with instructions. 10. Interpreting findings of physician to principal and teachers.

The chief purpose of the pupil health record is to provide an historical account of the pupil's health status during his school life. It should serve physician, nurse, and teacher in the following ways: checking improvement and searching for causes of a lack of improvement, seeking possible causes for scholastic retardation or failure, interpreting physical causes for behavior difficulties, peculiarities of personality, and social acts. It should serve, furthermore, as a basis for advising both pupil and parent with regard to hygiene and treatment, determining a pupil's fitness for certain occupations, and as a record of immunity in time of epidemic as well as a basis on which to build purposeful health instruction.

The health record card is an important element in the health examination, for it serves as objective evidence of the pupil's health

status. The school program of the pupil is built around his health record. The card presents a word picture of physical fitness of the pupil, his handicaps, and recommendations for correction of remediable defects. The record of results of follow-up work done by the nurse is of much value to the teacher in planning her program for the pupil.

The face of the card, which is an 8 x 5 size, is divided into three parts namely: identification, cumulative health findings, key for interpreting health examinations. Identification includes the name and address of pupil, date of birth, sex, color of the pupil, and parents' nativity. Space is provided for recording the date of the health examination, the grade, height, weight, and all other general physical defects, conditions, or diseases. The card is devised for cumulative examinations and serves the pupil throughout his school life. At the bottom of the card is recorded a method for interpreting the health findings of the physician. This is a simple and very complete key.

The reverse side of the card also is divided into three parts: history of contagious disease with date of infection, immunization with date of inoculation, results of follow-up work with dates. Contagious disease includes both major and minor infections. Immunization record includes vaccination against small pox, and immunization against diphtheria. The test information includes results of Schick and tuberculin tests. Considerable space is given over to results of follow-up work done by nurse.

The Providence Health Record Card has been revised several times. The same card is used in the parochial schools here. The Rhode Island communities of Cranston, Warwick, North Providence, and Johnston are also using the same pattern in their schools.

In the elementary schools the cards are kept in classrooms. In the junior and senior high schools they are filed either in the guidance office, or main office with the exception of the 7B and 10B cards which are filed in the office of physical education teachers until the health examinations have been completed.

The cards of the pupils who leave school before graduation are sent to the central records office in the Administration Building, as part of permanent School Archives. The cards of the pupils who graduate from high and trade school are held at the school for a period of five years and then sent to the central records office for permanent reference.

There should be a health record card for each pupil examined, on which the findings of the physician in the examination are

DEPARTMENT OF PUBLIC SCHOOLS
PROVIDENCE, RHODE ISLAND
HEALTH AND PHYSICAL EDUCATION

PUPIL'S HEALTH RECORD CARD

Schools

1 ..... 4 .....

2 ..... 5 .....

3 ..... 6 .....

Name..... Address .....
Last First

Date Birth..... Sex..... Color..... .....

Parent's Nativity..... .....

DATE OF HEALTH EXAM.	GRADE	HEIGHT	WEIGHT	NUTRITION	GLASSES WORN	VISION TESTS R	VISION TESTS L	STRABISMUS	HEARING TESTS R	HEARING TESTS L	EAR CANAL	TEETH	NOSE	TONSILS	Glands Cerv.	Glands Thy.	SKIN	SCALP	HEART	ORTHOPEDIC	LUNGS	NERVOUS SYSTEM	SPEECH	OTHER DEFECTS OR DISEASES

NUTRITION
(1) (2) (3)
1—Glasses worn

STRABISMUS
H.S.1

EAR CANAL
1—Slight
2—Discharge

TEETH
1—Unclean
2—Decayed
3—Abscessed

NOSE
1—Slight
2—Serious
3—Sus. Adenoids

TONSILS
1—Slight
2—Serious

GLANDS
1—Slight
2—Marked

SKIN
1—Minor
2—Contagious

SCALP
1—Nits or Lice

HEART
1—Functional
2—Organic

ORTHOPEDIC
1—Slight
2—Marked

LUNGS
1—Rales
2—Dullness

NERVOUS SYSTEM
1—Abnormal
2—Chorea
3—Epilepsy

SPEECH DEFECT
1—Slight
2—Marked
X—Treatment Advised

recorded. These cards should be available to the principal and teachers at all times for consultation regarding the pupil's physical condition. The health record card should be transferred with the pupil from school to school, and when the pupil leaves school it should be filed among permanent records.

Notification slips should be given to pupils for only those defects which may be remediable. The pupils should take the slips home to the parents and solicit their cooperation in securing immediate attention which is necessary for their best physical welfare. This notification slip urges the parent to consult with the family physician or family dentist regarding treatment. When the family is unable, for financial reasons, to secure the service of a physician or dentist, the nurse, after inquiring into the home conditions, refers the case to a medical, surgical, dental, ophthalmic, otologic, or orthopoedic clinic.

In cases where parents request that the child not be examined by the school doctor, the principal should give a note or statement to the pupil as well as a copy of the health record card and ask that the examination be made and the card filled in by the family physician. The card should be returned to the school, allowing at least one week in which to have the examination made.

The Follow-up program:—The purpose of the health examination is to remedy harmful conditions that may be discovered and to prevent other undesirable conditions from developing. In other words, the examination is but a means to an end. A report of the examination should be made to the teacher who should cooperate in securing the correction of any defects. As soon as possible after the examination is made, the parents should be officially informed of the remediable defects that have been found. It is not the function of the school to correct defects or to recommend what particular action should be taken by the family physician in reference to them. After the report has been made to parents, the nurse should follow the case in the home to learn what has been done to remedy defects. Through conference with the parents, every effort should be made to secure an adequate treatment of the defects.

Remedial program:—The summer vacation period is commonly recognized as a most convenient and effective time in which to bring about the remedying of defects. This is especially true of conditions requiring surgical treatment. The best time for preschool examinations is in the spring in preparation for the summer round-up. Also, during the summer parents are more willing to have medical and surgical treatment as the weather is less likely to be unfavorable. It is not always possible for parents to have family

physicians remedy defects. Under such circumstances, the nurse should endeavor to have the parent take the child to a clinic for such service as is necessary. If no clinical facilities are provided by the community, the school may make temporary and emergency provisions for treatment until the community can be led to provide such facilities, rather than to allow the health of the children to suffer. The permission of parents should, of course, be secured before any action is taken affecting the child.

In addition to the giving of treatment of an emergency nature, the schools, more than any other agency, are justified in carrying on these corrective activities in which the educational opportunities are very significant. There are forms of corrective measures that should be applied in the schools to prevent removing the child from the school, with the attendant educational loss. This policy has led to the establishment in Providence of open air and rest classes for the undernourished, cardiac, weak and anemic; a school for crippled children, classes for sight conservation, and mentally deficient as well as instruction for the hard of hearing, and those with speech defects. As a rule, no child should be segregated in a special class or school unless the educational and other gains to the particular child and the normal children from such a course are greater than the loss that always attends segregation.

Cardiac Cases:—Special consideration is given in Providence, in remedial measures according to the needs of each case as follows: besides the annual health examination and a check up with the family physician or hospital, pupils are excused from all physical and extracurricular activities; assigned to rest periods during school hours; given changes in program, either to reduce the daily schedule or to lessen the amount of going up and down stairs; also given a shortened school day and a limited activity program both in school and at home.

Dental Care:—Because of the universal need of dental care for children, school dental work is assigned a prominent place in the school health program in Providence. Each child has an examination of the teeth by a dentist or physician from the kindergarten through the fourth grade, and again in the junior and again in the senior high school. All cases needing special attention are referred to the family dentist, or to the school dentist for the lower grades when the family is unable to provide for necessary care. The work done by the school is preventive and educational in nature, and only such fillings and extractions are made as are of the emergency type and to teach the child how to properly care for his own teeth. Free treatment should be given only when it cannot possibly be provided

otherwise.

Nutrition:—The problem of the undernourished child is significant. This is complicated by economic conditions together with possible predisposed and inherited tendencies. The pupils should be brought to the attention of the school physician and nurse by the classroom teacher, who performs an important function by helping to conserve the energy of the children during the school day.

The practice of providing undernourished children with a mid-forenoon or mid-afternoon lunch, usually a bottle of milk and crackers or cookies, has been questioned by many health administrators and physicians. Often many of the children participate whose physical condition is not deleterious enough to warrant the practice. Also, there seems to be some evidence that the parents neglect to provide a proper breakfast or lunch, and that it interferes with the noon meal, leaving a net loss from the procedure. The emphasis has shifted to an effort to provide for undernourished children the right kind of noon meal in crippled, open air, and sight conservation classrooms, in the school cafeteria and through the school nurse, to bring about proper meals and sleeping conditions in the home.

In conclusion, it is essential to the success of the school health program that all unite in an endeavor to secure a cordial spirit of cooperation among the following forces: school physicians, nurses, principals, teachers, custodians, parents, family physicians, family dentists, city and state health officers, home visitors, and all agencies, public and private, concerned with the welfare of children. Working together as a team, these separate yet related individuals and services thus are enabled to pool their efforts in improving the health of school children.

Preliminary to the examinations the following directions are issued to Principals and Teachers:

Health Examinations: The examinations will be conducted in the kindergarten, 1B, 4B, 7B, 10B grades; all special health groups including crippled children, sight saving, open air classes, and rest groups at Kenyon and Windmill; any other pupils whom the teachers desire to have examined; also all students entering Trade School. The new health record cards are to be used for new pupils only, (i.e., those entering Providence Public Schools for the first time). For pupils who have been in school the old cards will be used.

Health Record Cards: Send these cards with pupils when they are transferred, and expect to receive from other schools the cards of pupils transferred to your school.

Health Examination Room: It will be greatly appreciated if the principal will kindly make available and place at the disposal of the school physician such conveniences as will be most helpful in conducting the examination in as much privacy as possible and with the least disturbance to the school.

Health Investigation: When calling the school health office for services to investigate cases of pupils who are absent owing to illness, please leave the message giving name of school, name of pupil, age, grade, address, and possible cause of absence, i.e., rash, sore throat, cough, etc.

Dental Clinics: Will be open Monday, October 23. The service will be for pupils of the kindergarten and the first, second, third, and *fourth* grades.

Sight and Hearing Tests: The annual reports of the eye and ear tests will be due Monday, December 4th. Only the TOTAL *sheet* should be sent to this office. Eye charts may be obtained on request from the school health office. The school nurse will make the hearing test of pupils in grade 1B. The teacher will make the test in the 1A, second, and third grades. Vision tests should be made of all pupils in the elementary schools, grades one through six; while in the junior high schools they will be made in grades seven through nine by health teachers. Make these tests as soon as possible so that school physicians may give attention to them when they visit the schools. *The audiometer tests will not be made this school year.* Please remember that pupils whose vision or hearing appears to be defective are to be reported to the school nurses at the time of their school visits, rather than to the parents. Report blanks will follow this letter. CHARLES B. LEWIS, M.D., *Director*

Approved: CHARLES F. TOWNE, *Deputy Superintendent*

In 1943-1944 there were 14,557 pupils examined of which 6028, or 41% were defective, and had a total of 7037 defects.

The more common defects found were: teeth 4339 or 61%; tonsils 1458 or 20%; vision 442 or 6%; heart 325 or 4%; and skin 144 or 2%.

There were 1233 boys examined for varsity athletics; junior high school, 248; senior high schools, 985; and Trade School 0.

There were 144 girls examined for varsity athletics in senior high schools.

There were 259 inspections made: elementary 202; junior high schools 30; senior high schools 27.

DANGER AREAS IN PHYSICAL EDUCATION

By C. L. LOWMAN, M.D.
Orthopedic Consultant, Los Angeles City Schools

I recognize fully that when a doctor discusses the dangers inherent in athletic activities, coaches and physical directors are prone to say: "Doctors get all stirred up about athletic injuries without realizing that of thousands of participating students, only a small percentage are injured." Taking this attitude, they still continue certain traditional exercises and activities which may result in injury to the human material which they handle.

It is true that certain pressure brought to bear on coaches and directors makes it very difficult for them to avoid harmful activities, even though they are eager to do what is right and to avoid risk to their pupils. This regrettable pressure has several causes:

1. Ambition of coaches to turn out winning teams or uphold a school's reputation for athletic prowess.
2. Their desire to promote possibilities of personal advancement with corresponding increase in compensation.
3. Desire of the students, both individually and collectively, to engage in competitive sports.
4. Pressure from parents who wish their sons to be "he-men" because they themselves played on the varsity, or because their sons may not seem to be very vigorous. Pressure, too, from alumni, because the social stimulus of the alumni requires winning teams.

These few of the many causes for pressure are enough to illustrate the point. Remedy for the first two is squarely up to the administration heads. No man should be kept on the pay roll who ignorantly or ruthlessly projects a program to build winning teams merely for the glory of the school or to foster his own advancement.

As to the third point (pressure from the students): It requires much diplomacy to steer the healthy desire of eager, ambitious youths into safe channels of activity with minimal amounts of stress. Boys of fourteen to sixteen, many of whom are husky and well-developed, are not structurally or organically equal to the demands of prolonged, heavy competitive activities. Such boys' future athletic careers or health itself, may be marred or ruined thereby. This "burning out," Coach Robertson of the University of Pennsylvania described some years ago in an excellent article, "Burning Up Boyhood," which appeared in the Saturday Evening Post. Coach Robertson in this article especially emphasized the

fact that many renowned champions had never had any gymnastic or athletic training in high school. In his opinion, the use of competitive track and field activities, basketball and football at early age levels not only reduces the student's athletic possibilities in college but may injure him because of impairment of the cardio-vascular mechanism and reduction of the endurance and responsiveness of his muscles. I wish to add further that continued stress on joints and growth cartilages, in the presence of faulty body mechanics from postural deviations, will later show the effect of accumulating trauma.

Regarding points four and five (pressure from parents or alumni) : Physical directors and coaches who appreciate the vulnerability of children at the seventh to tenth grade ages, must have the whole-hearted interest and sympathetic backing of their principals and supervisors in meeting this pressure and influence from parents and alumni. Explanation to the parent-teacher groups regarding the dangers of ill-advised activities to present and future health may aid in having a safe, constructive program understood. If the administrators appreciate the fact that all the students should be considered and not just the stronger selected few, they will support the coaches and directors who wish to raise the health standards of the school instead of its athletic rating.

To me it is inconceivable that men who drive automobiles and have some general mechanical knowledge often show so little consideration of the human machine which is subject to the same mechanical laws. Why should they expect the bearings (or joints) to continue to take stresses without showing wear? Why continue to "build muscle," that is, increase the motor force without seeing that the mechanical alignment is true? Every driver realizes that a motor car could not stand long-continued wear and tear with bearings not true. Why should the fact not be faced that about 75% of our children have some postural deviations? Just another way of saying that their machines are out of alignment. Orthopaedic surgeons and medical examiners noted these deviations during World War I when 50% of draftees were found physically deficient.

Yet, what was done by school administrators, coaches and directors of health and physical education in following years to offset this condition? Were methods and technics questioned? Were traditional ways given up or altered? Did school authorities recognize that because a man was an exceptionally fine football or basketball player while in college, he was not necessarily qualified to

handle growing boys? Even graduates in Physical Education are unqualified for such responsibility unless their courses have emphasized health education and body mechanics rather than recreational play and athletics.

During the present war, men have been placed in positions of influence over our youth who have never given much but lip service to health education and who could not correctly answer questions on the kinesiological analysis or biomechanics of the very athletic and gymnastic acts which they supervise.

When leading educators make statements in the press favoring "toughening our youth," how many have added "but not too early?" How many of them appreciate that youth should be guided through the danger areas of the preadolescent and adolescent periods? Many of you are doubtless tired of hearing me quote Jansen's Law of the Vulnerability of Fast Growing Cells, but I must have failed in explaining its significance since nearly every week in clinic and private practice I see the harmful results of competitive Junior High and early High School football on growing and immature youth.

To return to my opening points. You are saying to yourselves: "There he goes, talking about the few injured without regarding the thousands playing." Let me answer by saying that during twenty years of weekly consultations at the University of Southern California, a continuous flow of men and women have come to me with foot, knee, back and shoulder troubles. In a high percentage, their history reads: "I have had trouble ever since my high school days."

In practically every lecture I have given on trauma and postural stress on joints some students have wanted me to "feel how my knee cracks." I recall especially one well known old-time football coach who did this. One of the most famous quarterbacks at Southern California University came to me a year or so after college with a bad knee. X-ray showed many calcified bodies in the joint and a severe chronic synovitis. Surgical removal of these loose bodies was recommended. Note that the repeated minute trauma to the synovial lining from deep knee-bends, duck waddle, Russian Bounce, and similar exercises may accumulate for several years and become a potential for later trouble. Naturally, when there already exists some degree of postural malalignment, such as knock knee, bowlegs, back knee, tibial torsion, or pronated ankles, this trauma will be intensified from such exercises. The orthopaedic expression "postural strain" includes irritation of joint linings and cartilages, tension on and/or stretching of joint ligaments,

myositis or muscle inflammation, soreness or pain evidenced through the nervous mechanism, congestion, and sometimes swelling.

Pains around the joint, formerly known as "children's growing pains" now are more accurately recognized as postural strain. Since the epiphyseal lines or growth plates are close to the joints, irritation and inflammation in them are probably included in the same category. You can readily see that the malaligned structures of children with postural deviations are necessarily more prone to shock and strain than when joint alignment is normal. Likewise, if a normally aligned, well built child in a rapid period of growth is liable to injury under heavy activity, children with static and postural faults are in double danger.

How are these children to be protected? Well, all of you coaches and physical directors who can hold a plumb line or use a tape measure can check the run-of-the-mill school child. You will readily see that 50% to 75% of your pupils have some postural faults and will realize that bad body mechanics plus vulnerability in a stage of rapid growth equals potential if unseen injury.

Another point to consider is the relation of organs to structure. A student's being apparently strong and well and of a certain height and weight is no criterion of maturation from the organic standpoint. Nor does it imply that the glandular, nervous and mental mechanisms are in balance with growth and/or physiological demands. During the years we are concerned with in this discussion, nature is working hard to increase organic function to meet growth and activity demands. Neuromuscular and biochemical processes are also under stress. These factors cause so many adolescents to seem constantly tired, and parents are disturbed becaue the boy or girl seems lazy, irritable, unstable emotionally, and having hard work in school.

Just realize that growth is work, and work—organic, mental, or muscular, promotes fatigue. Therefore, in addition to the stress and strain to which the adolescent is subjected do not burden him further by ill-advised gymnastic and athletic activities. In connection with this fatigue factor, let me warn you that medical authorities have long recognized that fatigue lowers resistance to infection. Because boys who appear strong feel that they are vigorous and virile, unlikely to become sick, does not mean that they may not succumb to a serious infectious or contagious disease when they are fatigued and nature's guards are down.

I have seen many such instances, and investigators working

under grants from the National Foundation for Infantile Paralysis point out that fatigue is a very potent influence in the development and the severity of an attack of this disease. Many individuals may be infected and never know it. While resistance is high their ability to resist and throw off the disease is good, but if resistance is lowered they may go on into the systemic stage of an attack. In a college outbreak of polio it has been observed that most patients became involved after a strenuous week-end. If then, even the older students of late high school and early college years suffer from troubles attributable to fatigue, poor body mechanics and organic stress, are you going to continue to place stress on the younger adolescent group?

Let me reiterate my plea that you show more consideration for these young charges of yours. Make an effort to decrease potentially harmful strenuous exercises and hard competitive activities. Correct existing faults while there is still time and do not be misled by over-zealous patriotic motives into furthering ill-advised activities which will actually promote later injury or ill health to American youth. This does not mean giving up everything that youth desires, but means the adoption of methods that will meet static and structural needs. Call the work "commando" preparation if you wish, but omit the "toughening up" idea, leave the heavy work to later age groups and get down to fundamentals.

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School Health Study.—Clair E. Turner, Dr.P.H., formerly professor of public health, Massachusetts Institute of Technology, Cambridge, Mass., is conducting a statewide school health study in Kansas under the direction of Dr. Floyd C. Beelman, Topeka, secretary and executive officer of the State Board of Health, and Miss May Hare, health education coordinator in the State Health Department. The study aims to formulate policies, set up standards and make specific recommendations for building strong local health programs. — The Journal of the American Medical Association, December 23, 1944.

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Cancellation,—The Annual Conference of the American Association for Health, Physical Education, and Recreation, which had been set for April 21-24, 1945, at St. Louis, has been cancelled owing to the transportation emergency.

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EDITORIAL

In an article in this issue of the Journal, C. L. Lowman, M.D., one of the leading orthopedic authorities in this country, and a writer of note in the field of corrective physical education, raises a warning signal against the dangers of strains and injuries resulting from competitive athletics, especially at the adolescent age when immaturity of organs and joints render overdoing more easy and injury more likely.

Several articles and editorials appearing in the Journal of School Health have shown the great dangers of intensive athletic competition when those concerned are in early adolescence.

Not only has the danger of overstrain of vital organs been emphasized—and now Dr. Lowman brings to attention serious injuries to joints resulting from repetitive bruising or strain—but researches in the statistical field of injuries have shown that the young adolescent is more frequently and more seriously injured than is the older youth.

It is not only that high schools and—sad to say—junior high schools have been coërced into having interscholastic teams, but they are guilty of an apelike imitation of college rules that make a game much too strenuous for the immaturity of high school pupils. Any suggestion for modification that will make the games safer for these immature folks is ignored or ridiculed.

During the present war much publicity has been given to the many cases of prominent athletes who have been barred from national service, because of some injury caused by athletic competi-

tion, while the man concerned returns to intense professional competition. If the 4 F or other restricted classification is honest, this situation is a serious charge against intense competitive athletics as a factor in national welfare.

Moreover, if our interest is mainly in competitive athletics at the college level, almost any college sports coach can cite cases of potentially great athletes who have been ruined for college competition by a too intense or a too lightly guarded program of "interscholastic" sports at the high school level.

Careful consideration of this whole subject leads us to conclude that we have built a tower of competition much too high on a too narrow totally inadequate base. We need seriously to modify our program, both at the secondary school and at the college level. There should be a far greater *diversity* of opportunity for competition without the stress and strain of an overexcited interschool competition. This, in turn, makes necessary a greatly diversified and amplified mass of facilities for carrying on a more general program.

The publicity given these athletes—excused from military service because of physical defect while they continue to compete in intensive combat in baseball, hockey, and football—has left a very foul taste in the mouths of many more patriotic citizens. So, too, have the refusals of some school and college faculties to set up and to maintain a general compulsory physical training program for *all* students.

Unless attitudes and actions are favorably altered in these particulars, a nation-wide program for compulsory military service is inevitable. The groups fostering the present set-up in athletics and showing a chilly attitude toward required physical upbuilding programs cannot effectively argue against general military service—claiming that a program of physical training will do all that is needed—unless they take immediate and vigorous steps to make effective a general, scientifically planned and administered group of vigorous activities in schools and colleges that will reach *all* youth with *safety*.

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Chair of Child Health Established in London.—With Lord Nuffield's approval the trustees of the Nuffield Foundation have allocated $50,000 a year for ten years to provide a chair of child health in the University of London, an offer which has been gratefully accepted by the trustees of the University. This grant will enable a postgraduate institute of child health to be created for teaching and research on all aspects of child health. It is proposed that the institute shall be associated with the principal children's hospital in this country—the Hospital for Sick Children, Great Ormond Street, London—and with the obstretric department of the British Postgraduate Medical School at the Hammersmith Hospital. Lord Nuffield and the trustees of his foundation believe that the promotion of child health must have a prominent place in the organization of the future health services of the country. They appreciate that the development of research and training in this sphere requires new and enlarged facilities. They desire that the exceptional resources of the University of London for postgraduate education and research may be developed in a manner which will make the new Institute of Child Health worthy of the capital city of the empire.

The provision of academic centers for the teaching of child health has already been undertaken in several provincial universities, and the Nuffield Provincial Hospital's Trust has within the last three years made a substantal contribution to the University of Durham to assist in creating a chair of child health at King's College, Newcastle-on-Tyne. Edinburgh has had such a chair since 1931, and another has just been established at Liverpool by collaboration of the university with the city council. The title of the new chair is noteworthy. This country has never been backward in the study of pediatrics; on the contrary, it has made great advances in that subject. But "Hospital" or "Department for Diseases of Children" has always been the designation for the institution concerned. Now the idea has become popular that the medical profession has been too preoccupied with the treatment of disease, and that prevention, or the preservation of health, should have a more prominent place as an objective. Calling the government's projected scheme a "National Health Service" instead of a "National Medical Service" is a case in point. Journal A.M.A., October 28, 1944. pg. 582.

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MEETINGS

The Third Wartime Conference of the American Public Health Association and of the **American School Health Association** will be held at Chicago, Illinois, September 17-20, 1945.